Physical Therapy & Sport Services/ New York Balance & Vestibular PT
1373-28 Veterans Memorial Hwy
Hauppauge, NY 11788

Patient History

Today's Date: _____
Name _____ **Date of Birth** _____

Gender: ☐Male ☐Female **Height**: _____ **Weight**:_____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated
With whom do you live? ☐Alone ☐Spouse ☐Children ☐Other relatives ☐Personal attendant ☐Other
Where do you live? ☐Private home ☐Private apartment ☐Rented room ☐Assisted living ☐Other
Employment: ☐Full time ☐Part Time ☐Retired ☐Homemaker ☐Student ☐Not working ☐Disabled

Emergency contact _____ Telephone _____

Primary care physician _____ Telephone _____

Referring physician (if different)? _____ Telephone _____

Living environment
Does your home have:
☐Entry stairs ☐Railing ☐Inside stairs ☐Railing ☐Bathroom equipment (i.e. shower seats, rails)
Do you use:
☐Cane ☐Walker ☐Wheelchair ☐Motorized mobility ☐Glasses ☐Hearing aids

Current condition / Chief complaint
Please describe the problem for which you are seeking physical therapy: _____

_____

_____

_____

When did the problem begin? Month _____ Year _____

Describe what happened: _____

_____

Have you ever had the problem before? ☐Yes ☐No
If yes, what did you do for the problem? _____

Did the problem get better? ☐Yes ☐No

About how long did the problem last? _____

How are you taking care of the problem now? _____

What makes the problem better? _____

What makes the problem worse? _____

Check all that describe your symptoms:
☐Pain ☐Limited Motion ☐Weakness ☐Swelling ☐Difficulty Walking ☐Unsteady ☐Lightheaded
☐Headaches ☐Nausea ☐Dizziness ☐Rocking/swaying ☐Hearing loss ☐Ringing in ears

If you have dizziness, Do you ever feel like the room is spinning? ☐Yes ☐No.
If yes, how long does it last? ☐Seconds / minutes ☐Hours ☐Days

Have you had any falls within the past 12 months? ☐Yes ☐No. If yes, how many? _____Injuries? ☐Yes ☐No

Have you had therapy for this condition before? ☐Yes ☐No If yes, how long ago? _____

Please continue to the next page

Functional Status (check all that apply)

☐Difficulty with movement
☐Rolling in bed ☐Getting into / out of bed ☐Getting out of a chair ☐Moving from bed to chair
☐Walking : ☐On level surfaces ☐On ramps ☐On uneven terrain ☐In the dark
Difficulty with self care
☐Bathing ☐Dressing ☐Eating ☐Toileting ☐Other: _____
Difficulty with home management
☐House chores ☐Shopping ☐Driving ☐Care of dependents ☐Other: _____
Difficulty with community and work activities
Work activities: _____
Other activities: _____

General Health Status
Please rate your health: ☐Excellent ☐Good ☐Fair ☐Poor

Medical / Surgical history
Allergies (*please list any*): _____
Please check if you have ever had:

☐Osteoarthritis: _____
☐Rheumatoid arthritis
☐Joint replacement: _____
☐Osteoporosis
☐Broken bones / fractures _____
☐Neck pain _____
☐Back pain _____
☐Hypertension (high blood pressure)
☐Heart attack
☐Pacemaker
☐Heart valve problems_____
☐Other heart problems _____
☐Diabetes: ☐Type I ☐Type II
☐Neuropathy
☐Asthma
☐Emphysema
☐Other lung problems _____
☐Glaucoma
☐Macula degeneration
☐Cataracts
☐Other vision problems _____
☐Head trauma
☐Brain Injury
☐Stroke
☐TIA (mini stroke)
☐Parkinsons disease
☐Multiple Sclerosis

☐Seizures / epilepsy
☐Spinal cord injury
☐Spinal stenosis
☐Hearing loss
☐Vertigo
☐Meniere's disease
☐Vestibular problems (inner ear)
☐Cancer _____
☐Infectious disease (i.e. tuberculosis, hepatitis)
☐Kidney problems _____
☐Ulcers / stomach problems
☐Skin disease _____
☐Depression (required medication/ counseling)
☐Anxiety (requiring medication / counseling)
☐Problems with memory
☐Problems with attention
☐Problems with coordination
Other medical problems: _____
_____
Have you ever had surgery? Yes No
If yes, please describe and include dates:
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Please continue to the next page

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Medications

Please list your medications under the correct condition, Or attach a list:

Blood pressure	Heart	Cholesterol	Diabetes	Neurologic (i.e. stroke, Parkinsons, seizures, MS)	Others, including over the counter and supplements

Clinical / Diagnostic Tests

Within the past year, have you had any of the following tests? (Check all that apply)

- ☐CT scan of the head
- ☐MRI of the head
- ☐MRA
- ☐Hearing test
- ☐ENG (electronystagmogram)
- ☐BAER (brainstem auditory evoked response)
- ☐ECOG
- ☐Posturography
- ☐EMG (electromyogram)
- ☐NCV (nerve conduction velocity)
- ☐Carotid Doppler
- ☐Angiogram
- ☐Arthroscopy
- ☐Biopsy
- ☐Blood tests
- ☐Bone scan
- ☐Doppler ultrasound
- ☐EKG (electro cardiogram)
- ☐EEG (electroencephalogram)
- ☐Spinal tap
- ☐Stress test
- Other: _____

Other Healthcare Providers

Are you seeing anyone else for this problem? (Please list below)

_____

Pain Scale

On a scale from 1 to 10,

What is your pain:

Body part:			
Currently?			
At its worst?			
At its best?			

I certify that the above information is true and correct to the best of my knowledge. I will notify Physical Therapy &Sport Services/New York Balance & Vestibular PT of any changes in my health status or in the above information.

Signed: _____ Date _____

Patient or Authorized Representative

Please continue to the next page

PHYSICAL THERAPY & SPORT SERVICES, P.C.

NEW YORK BALANCE & VESTIBULAR PHYSICAL THERAPY

1373-28 Veterans Memorial Highway
Hauppauge, NY 11788
Phone (631)622-0150
Fax (631)622-0152

ASSIGNMENT OF BENEFITS

I authorize release of medical information to process this claim and authorize payment of medical benefits to Physical Therapy & Sport Services, P.C./New York Balance and Vestibular Physical Therapy for services described on your explanation of benefits statement.

Signature:_____ Date:_____/_____/_____

PAYMENT POLICY

All insurance co-payments are due at the time of service unless other arrangements are made with the billing department. Deductibles and co-insurance will be billed to you.

Signature:_____ Date:_____/_____/_____

CONSENT TO TREATMENT

I understand that I have been referred for physical therapy and rehabilitation treatment to Physical Therapy & Sport Services, P.C./New York Balance & Vestibular Physical Therapy and my individual treatment plan will be described to me. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Physical Therapy & Sport Services, P.C./New York Balance & Vestibular Physical Therapy provide treatment and care as prescribed for me by my physician and/or recommended to me by my physical therapist.

Signature:_____ Date:_____/_____/_____

Relationship to patient:_____
(parent or legal guardian of minor, spouse, etc.)

I WILL NOT SIT ON PHYSICAL THERAPY ROLLING STOOLS _____ (Please Initial)

Physical Therapy & Sport Services, P.C.

New York Balance & Vestibular Physical Therapy

Date: _____

Name: _____

How did you hear about our services and whom can we thank for your referral?

Name/ Source: _____

On occasion, we may need to make changes to the schedule due to unforeseen circumstances or inclement weather. If this situation may arise, we will make every attempt to contact you via phone and/or e-mail. Can we also e-mail you updates about our staff and services?

Yes, e-mail and phone ☐ No, Phone only ☐

E-Mail Address:_____

Contact Phone:_____

_____For office use only_____

Dr. referring patient_____